STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
			B. WIN			08/21/	2014
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				16TH ST		
CDUMNI	POINTE OF INDIAN	IAPOLIS			APOLIS, IN 46219		
	CROWNPOINTE OF INDIANAPOLIS			INDIAN	AI OLIO, III 402 19		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX				PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG				TAG	DEFICIENCY)		DATE
R000000							
	This visit was for	r the Investigation of	R00	00000			
	Complaint IN00	153457.					
	-						
	Complaint IN00	153457 Substantiated.					
	•	deficiencies related to					
	_	re cited at R296 and					
	R349.						
	Survey date: August 20 and 21, 2014						
	201709 0000. 110.	Sust 20 mm 21, 2011					
	Easility mymham	005720					
	Facility number:						
	Provider number						
	AIM number: N	r/A					
	Survey team: Pe	enny Marlatt, RN					
	J	,					
	Census bed type:						
	Residential: 64	•					
	Total: 64						
	Census Payor typ	pe:					
	Medicaid: 61						
	Other: 3						
	Total: 64						
	10mi. UT						
	G 1 2						
	Sample: 3						
	These state finding	ngs are cited in					
	accordance with	410 IAC 16.2-5.					
	Ouality review o	ompleted on August 25,					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

State Form Event ID: OVWD11 Facility ID: 005729 If continuation sheet Page 1 of 14

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPL	ETED
			B. WIN			08/21/	2014
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7365 E 16TH ST INDIANAPOLIS, IN 46219				
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE .	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
R000296	410 IAC 16.2-5-6() Pharmaceutical Se (b) The facility sha policies and proce assistance. The fa ongoing training to medication staff. Based on intervie the failed to ensu policies and proce assistance with in have been develor This deficient pri adversely affect a dministered me staff. (54 of 63 re Findings include During the initial between 9:05 a.m the Director of H she identified 63 current residents Additionally, she residents who are safely self admin the remaining 54	Fielden, RN. Dispervices - Noncompliance all maintain clear written dures on medication cility shall provide for the ensure competence of the wand record review, are clearly written reduces relating to the edications to residents appeal and implemented. The edications by facility residents who are dications by facility residents. I tour on 8-20-14 the edications who are in the facility. The edications who are in the facility. The edications is easiered to be able to dister their medications; the residents were	ROO	0296	RE: R0296 Submission of this plan of correction does not constitute admission of deficie or admission of guilt. All reside in the facility were at risk for the potential of harm by such deficiency, no residents were found to have been harmed. In Regards to failure to provide written medication administrati policy, our current policy has be updated to include specific instructions on the documentar process formedication administration when a resident's medication is not given and an explanation as to why is was not given. Update include the following: For all residents of are unable to self-medicate, medication will be administrative viaqualified staff. "All boxes of the MEDICATIONADMINISTRATICRECORDS SHEET (MARS) must be initialed, if a medication is	s ncy ents e on een t s who d n	DATE 09/30/2014
		nire assistance with nistration from the he facility.			notgiven the initialscorrespond with the time and date of said medication mustbe encircled. I each medication notgiven an		

State Form Event ID: OVWD11 Facility ID: 005729 If continuation sheet Page 2 of 14

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 CC			COMPL	ETED
			B. WIN			08/21/	2014
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			16TH ST		
CDOMN	POINTE OF INDIAN	JADOLIE			APOLIS, IN 46219		
CROWN	POINTE OF INDIAN	NAPOLIS		INDIAN	APOLIS, IN 402 19		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	In an interview v	with the DHS on 8-21-14			explanation is to be document	ed	
	at 12:45 p.m., she indicated she was				on theback of the MARS to		
	_	facility's policy on			include date,time, medication,		
		of medications was. She			reason not given andinitials of		
					staff person responsiblefor that particular medication pass"All	IL	
	did not indicate				QualifiedMedication Aides and	ΙΔΙΙ	
		als that were utilized by			nurses have been inserviced of		
	the facility for p	olicy, procedure or			new documentationprotocol.		
	concerns regarding any medications. She indicated she just utilized skills and knowledge she had learned from working in other nursing facilities.				Toensure that this process is		
					completed a series of checks		
					havebeen put intoplace. A		
					rotating schedule of auditswill		
					take place daily oneach shift.		
					Anew Medication Administration		
		h the Administrator on			Record Check off Sheet hasbe	een	
	8-21-14 at 2:30 j	p.m., she indicated the			created to enablethe staff to quickly check several records		
	facility did not h	ave a specific policy			eachshift. The check off shee	t is	
	related to medica	ation administration			to be completed andgiven to the		
	documentation.	She indicated she would			Director ofHealthCare Service		
		cations that had encircled			or her designee at the end of		
		R would have an			eachDay. The Director of		
					Healthcare Services or her		
		ten on the MAR or an			designee withreview this shee		
	1	ursing progress note.			daily, if any issues are found the		
	She indicated sh	e has spoken to facility			responsible staffperson will be contacted and instructed to ref		
	staff regarding "	about making sure forms			to the facilityimmediately to ma		
	are filled out cor	npletely."			any necessary documentation		
		. ,			The Directorof Healthcare	•	
	On 8-21-14 at 3:	45 nm the			Services or her designee with		
		-			perform a thorough audit of		
	_	rovided a copy of a policy			allMARS on a monthly basis to		
	1	ation Administration."			completed prior to the 15th of		
	This policy was indicated to be the current policy utilized by the facility. This policy indicated, "Residents of the				month for thepreceding month		
					To ensure that quality assuran		
					is being obtained thisprocess		
		eived medications as			continue for no less than a per		
	1 -	physicians to treat			of 6 months, atwhich point the process will be reviewed for		
	· ·				continuance. if thisquality		
	specific conditionsShould the resident				Continuation in this quality		

State Form Event ID: OVWD11 Facility ID: 005729 If continuation sheet Page 3 of 14

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING B. WING	ONPLE COMPLE				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7365 E 16TH ST INDIANAPOLIS, IN 46219				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE ROPRIATE	(X5) COMPLETION DATE	
	be incapable to self-administer medications with or without reminders, a licensed nurse or qualified medications aide shall be expected to administer medications as ordered by the physician and document the same"			assurance program is suc (if less than 10%of our clientalhave been affected this process will continue, the process will beupdate greater success	d) then , if not		
	indicated, "Medi significant cause mortality in the						
	This State tag re IN00153457.	lates to Complaint					
	3 0(0)						
R000349	on each resident. maintained under employee of the fa	Noncompliance st maintain clinical records These records must be the supervision of an acility designated with that records must be as umented. sible.					

State Form Event ID: OVWD11 Facility ID: 005729 If continuation sheet Page 4 of 14

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C	X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		COMPLETED	
			B. WING		08/21/2014	
NAME OF P	ROVIDER OR SUPPLIEF	3		ADDRESS, CITY, STATE, ZIP CODE		
				E 16TH ST		
CROWN	POINTE OF INDIAN	NAPOLIS	INDIA	NAPOLIS, IN 46219		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	COMPLETION	
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	Based on intervi	ew and record review,	R000349	RE 0349 In Regards to failure	e to 09/30/2014	
	the facility failed	d to ensure clinical		provide clinical records on		
	records accurate	ly reflect medications		eachresident that is complete accurately documented, reac		
		curately reflect dates		accessible, and systematically	,	
	•	resent in the facility and		organized . All residents in th		
	_	inistration records		facility were at risk forthe pot		
				of harm by such deficiency, r		
	` ′	tes present on each record		residents were found to have		
	for 3 of 3 residen			beenharmed. For all reside		
		inistration in a sample of		who are admitted to our facility	ty,	
3. (Resident #A, #B and #C)				orreadmitted to ourfacility.	aarda	
			Medication Administration re- will becompleted with resider			
	Findings include	2:		name, name, title at date of		
	8-			responsible for admitting the	otan	
	1 The clinical r	record of Resident #A		resident The Director of		
				Healthcare Services or		
		n 8-20-14 at 3:00 p.m.		herdesignee will complete		
	_	ncluded, but were not		a record check with in five da	· .	
	•	tage renal disease,		admit toensure that the resid		
	hemodialysis, di	abetes, hypertension,		name, staff name, title of date personcompleting admission	l l	
	aortic stenosis, a	nemia and diabetic		recorded on each page and t	l l	
	neuropathy.			all records are completeand		
				accurate. Allboxes on the		
	On 8-20-14 at 1	1:40 a.m. the		MEDICATIONADMINISTRAT	TION	
		rovided a listing of		RECORDS SHEET (MARS)	must	
	_	ad been transferred or		be initialed, if a medication is		
				notgiven the initials		
	_	the facility for the last		corresponding with the time a	l l	
	1	ent #A was indicated to		dateof said medication musts encircled. For each medicati		
	have been transf	Ferred to an area hospital		notgiven anexplanation is to		
	from 5-12-14 to	6-16-14; from 6-30-14 to		be documented on the back	of	
	7-2-14 and 7-10-	-14 to 7-11-14. This		the MARS to includedate,tim		
		she discharged from the		medication, reason not given		
	_	14 to an area health care		initials of the staff		
	facility.	17 to an area nearm care		personresponsiblefor that		
	raciiity.			particular medication pass"	l l	
				Qualified Medication Aides a	na	
	In review of the	nursing progress notes		All nurseshave been in		

State Form Event ID: OVWD11 Facility ID: 005729 If continuation sheet Page 5 of 14

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
			B. WING		08/21/2014
				ADDRESS, CITY, STATE, ZIP CODE	<u> </u>
NAME OF F	PROVIDER OR SUPPLIER			16TH ST	
	POINTE OF INDIAN		INDIAN	IAPOLIS, IN 46219	
(X4) ID		FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG		5.112
	for Resident #A, it indicated on 7-10-14			servicedon new documentatio protocol. To ensure that this	n
		one call had been		process is completedaseries of	of
	received from a f	family member which		checks have been put into	
	indicated the resi	ident had been		place. A rotating schedule of	
	transferred to an	area hospital from a		auditswill take place daily on e	each
	doctor's appointr	nent earlier in the day		shift. A new Medication	₄₄
	and had been adr	nitted to the hospital. It		AdministrationRecord Checko Sheet has been created to en	
		nily would contact the		the staff to quickly checksever	
		resident was to return to		recordseach shift. The check	
	the facility. The next entry in the nursing			sheet is to becompleted andgi	ven
	progress notes, dated 7-31-14 at 10:00			to the Director of HealthCare	
	a.m. indicated the resident had been			Services at the end of eachsh	ift.
				Toensure ongoing quality assurance the specific orienta	tion
	_	the facility upon family		training for newQMA's and LP	
	request to an area	a health care facility.		will be updated to include	
	D : 0D :1			specifics on the MAR Policy	
		ent #A's MAR for June,		andproper documentation for	
	2014 indicated sl			admits and readmits	
		d for the following			
	medications and	documentation of			
		dicated the following			
	information:				
	-Sensipar 60 mg	(milligrams) daily by			
	mouth; give after	r dialysis on Tuesday,			
	Thursday and Sa	turday. Blank			
		locks were indicated on			
	6-19-14 and 6-30)-14.			
		icrograms by mouth			
	'	dialysis on Tuesday,			
	Thursday and Saturday. Blank administration blocks were indicated on				
	6-19-14 and 6-30				
		ock side of the MAR and			
		ress notes did not			
	indicate any exp	lanations for the blank			

State Form Event ID: OVWD11 Facility ID: 005729 If continuation sheet Page 6 of 14

	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 08/21/2014		
	PROVIDER OR SUPPLIER POINTE OF INDIANAPOLIS	STREET ADDRESS, CITY, STATE, ZIP CODE 7365 E 16TH ST INDIANAPOLIS, IN 46219				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) administration blocks.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE COMPLETION		
	Review of Resident #A's MAR for July, 2014 indicated she was physician-ordered for the following medications and documentation of administration indicated the following information: -simvastatin 10 mg by mouth every evening. The MAR indicated encircled staff initials (typically indicates medication was not administered) on administration blocks on 7-2-14, 7-3-14, 7-5-14, 7-6-14, 7-7-14 and 7-8-14. A blank administration block was indicated on 7-15-14Synthroid 75 micrograms by mouth daily at early morning. The MAR indicated encircled staff initials on administration blocks on 7-22-14 and 7-23-14Nephro caps one capsule daily by mouth; give after dialysis on Tuesday, Thursday and Saturday. The MAR indicated encircled staff initials on administration blocks on 7-4-14 A blank administration blocks on 7-4-14 A blank administration block was indicated on 7-11-14. Review of the back side of the MAR and the nursing progress notes did not indicate any explanations for why the medications were not administered or the blank administration blocks.					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	00		(X3) DATE SURVEY COMPLETED	
ANDILAN	o. condection	EDENTIFICATION NOMBER.	A. BUILDING			21/2014
			B. WING	ADDRESS, CITY, STATE, ZIP (
NAME OF I	PROVIDER OR SUPPLIER	R		16TH ST	ODE	
CROWN	POINTE OF INDIAN	NAPOLIS		APOLIS, IN 46219		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	RRECTION	(X5)
PREFIX	,	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	HOULD BE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
		lent #A's June, 2014				
		icated 1 of 7 pages did				
		h and year indicated. The orm which indicated				
	-	hrough" and the portion				
	_	, "Completed Entries				
		le/Date," were blank.				
	Checked/Dy/11t.	ic/Date, were trails.				
	2. Resident #B's	s clinical record was				
	reviewed on 8-2	0-14 at 1:40 p.m. Her				
	diagnoses includ	ded, but were not limited				
	to, Guillian-Barre syndrome, bilateral lower extremity edema and chronic					
	kidney disease.					
	D. i CDii	1 //D! I. 1. 2014				
		dent #B's July, 2014				
	MAR indicated					
		ed for the following documentation of				
	information:	ndicated the following				
		rams per each 15				
	1	give 15 ml or 10 grams				
		daily by mouth. The				
	1 -	encircled staff initials				
		ites medication was not				
		n administration blocks				
	· · · · · · · · · · · · · · · · · · ·	doses on 7-1-14, 7-2-14,				
	_	7-6-14, 7-8-14, 7-10-14,				
		4, 7-15-14, 7-16-14,				
	· · · · · · · · · · · · · · · · · · ·	4, 7-21-14, 7-22-14,				
	· ·	4, 7-25-14 and 7-31-14.				
	· ·	stration block was				
	indicated for the	e morning dose on				
1	1		1			1

State Form Event ID: OVWD11 Facility ID: 005729 If continuation sheet Page 8 of 14

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING B. WING	00	COMP	ESURVEY LETED 1/2014	
	PROVIDER OR SUPPLIER POINTE OF INDIAN		7365 E	ADDRESS, CITY, STATE, ZIP CO 16TH ST APOLIS, IN 46219	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	A blank administindicated for the 7-26-14lisinopril 10 mg blank administration 7-26-14Coreg 3.125 mg A blank administindicated for the 7-26-14Prilosec 20 mg administration b 7-26-14Clonidine 0.1 m mouth. A blank was indicated for 7-26-14. Review of the bathen nursing progindicate any exp medications were blank administration. Review of Resident 2014 MAR indicated physician-ordered medications and administration in information: -Lactulose 10 gr milliliters (ml), gr milliliters	lent #B's August 1-21, cated she was ed for the following documentation of indicated the following				

State Form Event ID: OVWD11 Facility ID: 005729 If continuation sheet Page 9 of 14

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CC		, ,	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00		LETED
			B. WING		08/21	/2014
				ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹		16TH ST		
CROWN	POINTE OF INDIAN	NAPOLIS	INDIAN	APOLIS, IN 46219		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL)	O BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRODEFICIENCY)	PRIATE	DATE
	MAR indicated	encircled staff initials				
	(typically indica	tes medication was not				
		administration blocks				
	·	doses on 8-5-14, 8-6-14,				
		8-10-14, 8-11-14,				
		4, 8-15-14, 8-16-14,				
	8-17-14, 8-18-14					
	·	daily by mouth at				
		nk administration block				
	was indicated or					
		ack side of the MAR and				
	the nursing progress notes did not					
	indicate any explanations for why the					
		re not administered or the				
	blank administra	ation blocks.				
	3 Resident #C's	s clinical record was				
		0-14 at 2:35 p.m. His				
		led, but were not limited				
	_					
	l '	us and deep vein				
		pulmonary emboli (blood				
		sion, depression, anxiety				
	and pulmonary l	neart disease.				
	On 8 20 14 of 1	1:40 a.m. tha				
	On 8-20-14 at 1					
		rovided a listing of				
		ad been transferred or				
		the facility for the last				
	<u>-</u>	ent #C was indicated to				
		Ferred to an area hospital				
		7-22-14 and from 7-27-14				
	to 7-28-14.					
	In review of the	nursing progress notes				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY OO COMPLETED				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00		PLETED 21/2014
			B. WING	DDDDGG GYMY		. 1/2014
NAME OF F	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CO	DDE	
CROWN	POINTE OF INDIAN	NAPOLIS		16TH ST APOLIS, IN 46219		
				02.0, 117 102.10		(V5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO	OULD BE	(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE AP DEFICIENCY)	PROPRIATE	DATE
		, it indicated he was				
		area hospital on 7-9-14				
		returned to the facility				
	•	00 p.m. The progress				
		he was transferred to an				
	area hospital on	7-24-14 at 5:00 p.m., and				
	_	acility on 7-25-14 at 3:00				
	a.m.	-				
	Review of Resid	lent #C's MAR for July,				
	2014 indicated h	ne was physician-ordered				
	for the following medications and documentation of administration					
	indicated the fol	lowing information:				
	-Flexeril 10 mill	ligrams (mg) three times				
		Blank administration				
		icated on 7-28-14 for the				
	noon dose and o	on 7-30-14 for the evening				
	dose.					
		our times daily by mouth.				
		ation blocks were				
		8-14 for the noon dose				
		for the evening and				
	bedtime doses.					
		mg twice daily by mouth.				
		stration block was				
		0-14 for the evening				
	dose.					
	1	mg three times daily by				
		dministration blocks				
		on 7-28-14 for the noon				
		0-14 for the bedtime				
	dose.					
	-metoprolol succ	cinate 100 mg daily by	1			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			TE SURVEY IPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00		21/2014
			B. WING	DDDEGG GIENT GETTE		- //EU I-T
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP C 16TH ST	ODE	
CROWN	POINTE OF INDIAN	NAPOLIS		APOLIS, IN 46219		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	· 		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	IOULD BE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	TINOFRIATE	DATE
	mouth. The MA	AR indicated encircled				
	staff initials (typ	pically indicates				
	medication was	not administered) on an				
	administration b	lock for 7-23-14.				
	Review of the ba	ack side of the MAR and				
		ress notes did not				
		lanations for why the				
		re not administered or the				
	blank administra	ation blocks.				
		dent #C's July, 2014				
		icated 6 of 6 pages did				
		h and year indicated. The				
	_	orm which indicated				
	_	hrough" as well and the				
	_	ndicated, "Completed				
		l/By/Title/Date," were				
	blank.					
	In an interview v	with the Director of				
		(DHS) on 8-21-14 at				
		indicated she was unsure				
	what the facility					
	_	of medications was. She				
	did not indicate	any professional				
		als that were utilized by				
	the facility for p	olicy, procedure or				
	concerns regard	ing any medications. She				
	indicated she jus	st utilized skills and				
		nad learned from working				
	in other nursing	facilities. The DHS				
	indicated, "Whe	never we have to				
	handwrite the ne	ew orders or the monthly				
	orders [recapitul	lation physician's orders],				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	NSTRUCTION 00	(X3) DATE COMP	E SURVEY LETED		
			A. BUILDING B. WING			/2014	
NAME OF PROVIDER OR SUPPLIER CROWNPOINTE OF INDIANAPOLIS			STREET ADDRESS, CITY, STATE, ZIP CODE 7365 E 16TH ST INDIANAPOLIS, IN 46219				
(X4) ID PREFIX TAG	ID SUMMARY STATEMENT OF DEFICIENCIES FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
		the date is listed on the says on the form.					
	(physician's mor utilized by the fa Physician Signat statement regard	acapitulation orders athly orders) form acility indicated, "See ture on Last Page." A ating dating only the last a was not located on the					
	(physician's mor MAR form utiliz indicated "Chart "Completed Entr Checked/By/Titl	e/Date." Each form had a facility staff to enter					
	8-21-14 at 2:30 places facility did not have related to medical documentation. Expect any medical initials on a MA explanation writt accompanying numbers of the second se	the Administrator on p.m., she indicated the lave a specific policy lation administration. She indicated she would cations that had encircled R would have an laten on the MAR or an larsing progress note. The late is a spoken to facility labout making sure forms in the making sure forms in the late is a spoken to facility labout making sure forms in the late is a spoken to facility labout making sure forms in the late is a spoken to facility labout making sure forms in the late is a spoken to facility labout making sure forms in the late is a spoken to facility late is a spoken to facility labout making sure forms in the late is a spoken to facility late is a spoken to facili					
	On 8-21-14 at 3:	45 p.m., the					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 08/21/2014		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7365 E 16TH ST INDIANAPOLIS, IN 46219				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE		
	entitled, "Medica This policy was a current policy ut This policy indicated facility shall rece ordered by their specific condition be incapable to see medications with licensed nurse or aide shall be experimedications as of and document the and document the significant causes mortality in the Uninstitution must be place for the documedication administration administration and significant causes mortality in the Uninstitution must be place for the documedication administration.	r qualified medications ected to administer rdered by the physician e same" uide, Nursing 2014, cation errors are a of patient morbidity and United StatesEach have tools and policies in umentation of					

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